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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The best copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11825

11814

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Tobacco</u>		LENGTH OF STAY (In this place) —		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Tobacco</u>		STREET ADDRESS (If rural give location) <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				1 STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Babey</u> (Middle) <u>Bay</u> (Last) <u>Adams</u>				(Month) <u>11</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-1-57</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS <u>Mrs. Ruth Adams, Port Tobacco, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7168 IMMEDIATE CAUSE (A) <u>Prematurity - 25 weeks</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>—</u>							
(C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —							
19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION —		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) —			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) —		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? —			
22. I hereby certify that I attended the deceased from <u>midwife</u> to <u>10:05 P.</u> , 19 <u>11-2-57</u> , that I last saw the deceased alive on <u>11-2-57</u> , and that death occurred at <u>10:05 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>J B Dettor</u>		M.D. <u>La Plata Md.</u>		DATE SIGNED <u>11-2-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/2/57</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		LOCATION (City, town, or county) (State) <u>LAPLATA MD</u>	
24. REC'D BY REGISTRAR DATE <u>11/2/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Paay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth Adams</u>		ADDRESS <u>Port Tobacco, Md.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE

AGE

SEX

RACE

CAUSE OF DEATH

BUREAU V. S.

NOV 5 1957

RECEIVED

UNITED STATES

1

11815

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11826

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains, Maryland</u>			
c. LENGTH OF STAY IN TB <u>2 years</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas J. BEACH</u>				4. DATE OF DEATH Month Day Year <u>11 1 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept/29/1901</u>		9. AGE (In years lost birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William R. Beach</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>237 24 973</u>		17. INFORMANT <u>patient</u> or <u>deceased</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic lung abscess</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 21, 1956</u> to <u>Nov 1, 1957</u> , that I last saw the deceased alive on <u>Nov 1, 1957</u> , and that death occurred at <u>9:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. M. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata Md</u> DATE SIGNED <u>11-1-57</u>			
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>				ADDRESS (Street, city or town, state) <u>La Plata Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Full Gospel</u>		22d. LOCATION (City, town, or county) (State) <u>Codanville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				ADDRESS <u>WALDORE Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/5/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H. Mason</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11827

Reg. Dist. No. 100

11816

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pomfret</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>MARRILYN</u> First Middle Last				4. DATE OF DEATH <u>NOV 18 1957</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OF RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>APRIL 24-56</u> 1		9. AGE (In years last birthday) yrs. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>SWEENEY BEALE</u>			
14. MOTHER'S MAIDEN NAME <u>MARY P. TRAVERS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>SWEENEY BEALE</u> Address <u>Pomfret, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho-pneumonia</u> DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>11-18-57</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-18-57</u>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's Cem.</u>			
22d. LOCATION (City, town, or county) <u>Pomfret</u>		(State) <u>MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 11/22/57</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORF, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11817
CERTIFICATE OF DEATH

11828
100

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park <i>1517.2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.		d. STREET ADDRESS 7102 14th Avenue	
3. NAME OF DECEASED (Type or print) First William Middle Allen Last Billingsley		4. DATE OF DEATH Month November Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1903
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Baking Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Billingsley		14. MOTHER'S MAIDEN NAME Carrie B. Lusby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. —	
17. INFORMANT Roger H. Billingsley-5030 33rd Road, N.		Address Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.I.U.A. DUE TO (c) Carcinoma, lung, with metastases		INTERVAL BETWEEN ONSET AND DEATH 7 hrs. 6 hrs. 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 15, 1957 , to 11 Nov 1957 , that I last saw the deceased alive on 11 Nov 1957 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur C. Woody M.D.		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED Nov 12 1957	
PHYSICIAN'S NAME (Type) ARTHUR C. WOODY, M.D. LA PLATA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11/13/57	22c. NAME OF CEMETERY OR CREMATORY McKendree Cemetery	22d. LOCATION (City, town, or county) (State) Brandywine, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR Nov 12 1957 24b. REGISTRAR'S SIGNATURE Julius Posey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
1957
CERTIFICATE OF DEATH

RECEIVED
NOV 12 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11829

Reg. Dist. No. 100

11818

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Charles									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Waldorf							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles E Burch				4. DATE OF DEATH		Month Nov.		Day 24		Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 20, 1907		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Ambrose Burch						14. MOTHER'S MAIDEN NAME Mary E. Wood							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Edith Burch				Address WALDORE Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Fractured Skull & Fractured Neck</p> <p>812X DUE TO Crushed Chest, Bilateral Fractures(Comp)</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tibia & Fibula</p> <p>DUE TO Automobile Accident (Pedestrian)</p> <p>(c)</p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH Instantly </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian walking on highway hit by auto									
20c. TIME OF INJURY Month, Day, Year 6 11-24-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Waldorf		(County) Charles		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE Vernon B Dettor						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 11-25-'57				
EXAMINER'S NAME (Type) Vernon B. Dettor, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-27-57		22c. NAME OF CEMETERY OR CREMATORY St Peters Cem				22d. LOCATION (City, town, or county) WALDORE Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home						ADDRESS WALDORE, Md.		24a. REC'D BY REGISTRAR DATE 11/30/57		24b. REGISTRAR'S SIGNATURE Julia H. Hancy			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNITED STATES DEPARTMENT OF HEALTH - ATLANTA 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

DEC 3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11830

11819

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Mt Victoria</u> LENGTH OF STAY (in this place) <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Chas.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Mt Victoria</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Henry Carroll</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 1 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-16-81</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Carroll</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA CAROLINE CHAPMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Hannah M. Butler Newburg Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>C.U.A.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-sclerotic hypertension</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>48 hrs</u> <u>10 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>heart disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 47</u> , to <u>Nov 1 19 57</u> , that I last saw the deceased alive on <u>Nov 1 19 57</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wooddy MD</u>				ADDRESS (Street, city, town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>1 Nov 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-5-57</u>		NAME OF CEMETERY OR CREMATORY <u>Shiloh ME CEM</u>		LOCATION (City, town, or county) (State) <u>WAYSIDE, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>11/6/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Pasen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>		ADDRESS <u>WALTON, MD.</u>	

RECEIVED

NOV 1 1977

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11831

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) e. STATE <u>Ind</u> b. COUNTY <u>Chas.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grayton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Jessie S. DAVIS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30</u>
9. AGE (In years and months) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bryson</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carol B. Bryson Jr.</u>		Address <u>Grayton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>fracture left humerus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>40</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>11-12-57</u> <u>10-18-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall from left humerus</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>10-18-57</u> <u>12</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Grayton Chas Ind</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rebert Mc</u>		ADDRESS <u>Laplaton Md</u>	
24a. REC'D BY REGISTRAR <u>11/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia D. Parsey</u>	

DATE SIGNED

11-14-57

BUREAU V. S.

NOV 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please etc-
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please etc-
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please etc-

VS. A15ME(5)
 SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11832

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomonkey		c. LENGTH OF STAY IN 1b 86-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Pomonkey			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas Day First Middle Last				4. DATE OF DEATH 11-14-57 Month Day Year			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-70	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY US Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Alice Campbell- (Daughter)-Bryans Road Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Small Intestines 152x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							INTERVA. BETWEEN ONSET AND DEATH Indefinite
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James E. Andrews M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James E. Andrews MD.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CREMATORY Metropolitan Cem.		22d. LOCATION (City, town, or county) (State) Pomonkey Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				24a. REC'D BY REGISTRAR WALLOEF, M.D.		24b. REGISTRAR'S SIGNATURE Julia H. Pusey	

DATE SIGNED

11-15-57

BURIAL NO. 1

NOV 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

CERTIFICATE OF DEATH

11833

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician Memorial Hosp.				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Atticus Middle M. Last Earney				4. DATE OF DEATH Month Nov Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE US-W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Mar 1887	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10b. KIND OF BUSINESS OR INDUSTRY Industrial		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME M. D. EARNEY				14. MOTHER'S MAIDEN NAME MARY Chester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) PRE WWI				16. SOCIAL SECURITY NO. 220343572		17. INFORMANT Regina M. Earney Address Cobb Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse DUE TO C.U.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertensive renal disease (b) C.U.A. (c) Hypertensive renal disease						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 6 hrs 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcified prostate, chronically infected.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 1954, to 25 Nov , 1957 that I last saw the deceased alive on 25 Nov , 1957, and that death occurred at 4:46 P.M. from the causes and on the date stated above.							
21a. ACTUAL SIGNATURE Stowooddy M.D.				21b. ADDRESS (Street, city or town, state) La Plata Md DATE SIGNED 27 Nov 57			
21c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY MD							
22a. BURIAL, CREMATION, or MOVAL (Specify) BURIAL		22b. DATE THEREOF 11-29-57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntl Funeral Home ADDRESS WALDORE, Md.				24a. REC'D BY REGISTRAR 12/3/57		24b. REGISTRAR'S SIGNATURE John H. Pacey	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11834

11823

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		STATE <u>Md</u> COUNTY <u>Charles</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		LENGTH OF STAY (in this place) <u>58</u>		TOWN <u>Pisgah</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>N.</u> (Last) <u>Greer Jr.</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>17</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-13-99</u>	9. AGE last birthday <u>58</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS <u>Odd Jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Pisgah Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George N. Greer</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-8680</u>		17. INFORMANT & ADDRESS <u>John R Greer, Indian Head Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis Generalized</u>						<u>5 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) <u></u> (County) <u></u> (State) <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>11/7/57</u> , 19 <u>57</u> , to <u>11/19/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/13/57</u> , 19 <u>57</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank A. Jusan</u> M.D.				DATE SIGNED <u>11-17-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cem.</u>		LOCATION (City, town, or county) <u>Pisgah, Md.</u> (State) <u>Md.</u>	
24. REC'D BY REGISTRAR <u>Juan H. Carey</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORE, Md.</u>	
DATE <u>11/22/57</u>							

BUREAU V. 2

NOV 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13049

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT. #5, HUGHESVILLE</u> c. LENGTH OF STAY IN 1b <u>TRANSIENT</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission)) a. STATE <u>MD</u> b. COUNTY <u>St Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEXINGTON PARK</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>DAVID</u> Last <u>HODGES JR.</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug 28 1957</u>		9. AGE (In years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>OKLA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John D. Hodges, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Ellen Pate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>John D. Hodges, Sr.</u> Address <u>LEXINGTON PARK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIAATION; ASPIRATION OF STOMACH CONTENTS</u> DUE TO <u>216X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>BRAIN CONCUSSION</u> DUE TO (c) <u>—</u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>10 MINUTES</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>VEHICULAR COLLISION ON MD RT #5, 1 MILE SOUTH OF HUGHESVILLE, MD</u>			
20c. TIME OF INJURY Hour <u>11:20</u> p.m. Month, Day, Year <u>11/28 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) <u>HUGHESVILLE, CHARLES, MD.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John H. Griffin</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN H. GRIFFIN, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HUNT FUNERAL HOME</u> ADDRESS <u>WALDORF, MD.</u>		22d. LOCATION (City, town, or county) (State) <u>OKLA. CITY OKLA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>DATE 12/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Haney</u>	

MEDICAL CERTIFICATION

 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposal.

VS. A15ME(5)
SM 11/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11835
Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT #5; HUGHESVILLE		c. LENGTH OF STAY IN TB NONE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1369 PERRY PLACE, N.W.				d. STREET ADDRESS 1369 PERRY PLACE, N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES THOMAS JORDAN				4. DATE OF DEATH Month Day Year NOVEMBER 28 1957			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1913		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Maintenance		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME IRELAND JORDAN				14. MOTHER'S MAIDEN NAME JANE M. FENWICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNKNOWN		17. INFORMANT (WIFE) Address ESTELLE JORDAN 1369 PERRY PLACE, N.W. WASHINGTON, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X FRACTURE, SKULL, BASAL DUE TO (b) MULTIPLE FRACTURES (2-4-5-6-7-8 Ribs RT; RIGHT ULNA; RIGHT TIBIA; RIGHT FEMUR; RIGHT FIBULA) (c) COMPOUND, COMMINUTED FRACTURES OF LEFT TIBIA AND FIBULA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). TIBIA AND FIBULA							INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS INSTANTANEOUS INSTANTANEOUS
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) VEHICULAR COLLISION ON MD. RT #5, 1 MILE SOUTH OF HUGHESVILLE, MD.					
20c. TIME OF INJURY Hour 11:20 P.M. Month, Day, Year 11/28 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY		20f. (City or town) (County) (State) HUGHESVILLE CHARLES MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John H. Griffin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN H. GRIFFIN				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE 11/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Georges		22d. LOCATION (City, town, or county) (State) St. Georges Island MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf, Md.				24a. REC'D BY REGISTRAR DATE 12/3/57		24b. REGISTRAR'S SIGNATURE Julia K. Roney	

MEDICAL CERTIFICATION

BUREAU V. S.

RECEIVED

Item 20 Film 225 11826 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11836
 : 11826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 BRYANTOWN RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	

3. NAME OF DECEASED (Type or print) First <u>MICHAEL C.</u> Middle <u>PROCTOR</u> Last <u>PROCTOR</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 3 1944</u>
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	11. BIRTHPLACE (State or foreign country) <u>L'SIA</u>

13. FATHER'S NAME <u>Richard Hayes Proctor Jr.</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HAYES Proctor</u>		Address <u>WALDORE, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fluid and Electrolyte Loss</u> 916.0 DUE TO <u>Second Degree Thermal Burns - 100%.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>15 hours</u> (c) <u>15 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Kerosene stove explosion</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 P.M. 11-2-1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) (County) (State) <u>Malcolm Charles Maryland</u>

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>V. B. DETTOR</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>5 Nov. 1957</u>
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM</u>	22d. LOCATION (City, town, or county) (State) <u>LA PLATA Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u>		ADDRESS <u>WALDORE, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>11/11/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Julia Massey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

REAU V. 3

NOV 13 1951

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11837

11827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WELCOME</u>			
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY C. SHORT</u> First Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 17, 1928</u>		9. AGE (in years last birthday) <u>29</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No Job</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jessie Short</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Emma Whiting</u> Address <u>2205 Franklin NE. Wash., D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>5x</u> DUE TO <u>Cranial Trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Auto Accident</u> (b) <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>8 hrs.</u> <u>8 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>11-18 1957</u> Hour <u>12:50</u> a.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>PORT TOWN, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>V. B. Dettor</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>V. B. DETTOR, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. DATE OF CREMATION, REMOVAL (Specify) <u>During 11-20-57</u>		22b. DATE THEREOF <u>11-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION HILL Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hill Top, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				ADDRESS <u>WALDORE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>11/22/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H. Parney</u>			

08

RECEIVED

NOV 3 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11828

11838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) VERONICA SYLVIA THOMPSON				4. DATE OF DEATH 11-28 1957			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-57	
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR 3 Months 3 Days 3 Hours 3 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) LA PLATA, MD				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WM. GONZA THOMPSON				14. MOTHER'S MAIDEN NAME MARY ALINE PROCTOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT GONZA THOMPSON, LA PLATA, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased Intracranial Pressure DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 752x DUE TO 752x (c) 752x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 752x INTERVAL BETWEEN ONSET AND DEATH 70 days 70 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED 19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9-10 , 19 57 , to 9-10 , 19 57 , that I last saw the deceased alive on 9-10 , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE V.B. DETTOR				DATE SIGNED 11-29-57			
PHYSICIAN'S NAME (Type) V.B. DETTOR, M.D.				Address La Plata, Md.			
22a. BURIAL, CREMATION, REMOVALS (Specify) BURIAL				22b. DATE THEREOF 11/29/57			
22c. NAME OF CEMETERY OR CREMATORY St IGNATIUS				22d. LOCATION (City, town, or county) (State) BEL ALTON, MD			
23. FUNERAL DIRECTOR'S SIGNATURE HEHART FUNERAL HOME				24a. REC'D BY REGISTRAR 11/29/57			
ADDRESS LA PLATA				24b. REGISTRAR'S SIGNATURE Julia H. Basing			

4000318X04

CERTIFICATE OF DEATH

RECEIVED
DEC 2 1957
BUREAU V. S.

11829

CERTIFICATE OF DEATH

11839

Reg. Dist. No. 101

1. PLACE OF DEATH a. COUNTY <i>Charles Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Chas. Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironsides-Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironsides x2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>SARAH H. WARREN</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-15-1886</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR: Months <i>11</i> Days <i>15</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Chas. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Charles</i>	
13. FATHER'S NAME <i>John Henry Henson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Queen Pisgah-Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Edna Simmons, Ironside, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> 0533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>infected left foot</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-14</i> , 19 <i>57</i> , to <i>11-15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-14</i> , 19 <i>57</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>La Plata Md.</i> DATE SIGNED <i>11-18-57</i>			
ACTUAL SIGNATURE <i>F. M. JOHNSON</i> M.D.		PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-19-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Smith Chapel Church</i>	22d. LOCATION (City, town, or county) (State) <i>Pisgah Chas. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson and Jenkins</i>		24a. REC'D BY REGISTRAR DATE <i>11-18-57</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

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